DOCUMENT RESUME

ED 286 292 EC 200 469

TITLE Health Services for Children with Special Needs: Report of the Division of Services to Crippled Children for the Fiscal Years, 1984-1985, 1985-1986.

INSTITUTION Michigan State Dept. of Public Health, Lansing, MI. Div. of Services to Crippled Children.

PUB DATE Jan 87

NOTE 29p.

PUB TYPE Guides - Non-Classroom Use (055) -- Reports - Descriptive (141)

EDRS PRICE MF01/PC02 Plus Postage.

DESCRIPTORS Childhood Needs; Children; Community Services; *Disabilities; Family Programs; *Health Needs; *Health Services; Prevention; Public Health; *State Programs

IDENTIFIERS *Child Health; *Michigan

ABSTRACT

This report describes the recent efforts of Michigan's Division of Services to Crippled Children (DSCC) to assist families with handicapped children to develop their full potential for health, education, and self-support through the removal of physical, social, psychological, and economic barriers. DSCC functions are carried out at the local, regional, and state level. Major services include prevention, casefinding, diagnosis, medical care and treatment, and case management. Free diagnostic evaluation services are offered to all Michigan children with a suspected handicapping condition, and treatment services are provided for all children who are medically and financially eligible. The DSCC assists families by assuming all, or part of, the cost of related treatment for the handicapping condition. Care is provided by over 3,000 professionals of whom half are specialty-trained physicians. Locally Based Services, an endeavor introduced in 1983, provide community-based support for identifying and responding to the needs of those with chronic illness and handicapping conditions and their families. Future directions include: strengthening services delivered in the community; recognizing and supporting the significant role of families in the delivery of care; improving coordination between specialty and community care; and improving operational efficiency. (Author/CB)

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MICHIGAN DEPARTMENT OF PUBLIC HEALTH

HEALTH SERVICES FOR CHILDREN WITH SPECIAL NEEDS

Report of the

DIVISION OF SERVICES TO CRIPPLED CHILDREN

for the Fiscal Years

1984-1985, 1985-1986

STATE OF MICHIGAN

JAMES J. BLANCHARD, GOVERNOR

Gloria R. Smith, Ph.D., M.P.H., F.A.A.N.
Director

Denise Holmes, Chief
Bureau of Community Services

William Clexton, Chief
Division of Services to Crippled Children

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Authority: Act 368, PA 1978

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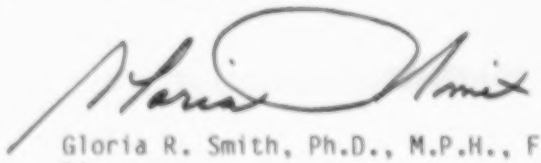
FOREWORD

Since 1927, the State of Michigan has sustained a commitment to children with physically handicapping conditions. While the health care system has changed dramatically, the mission of the Division of Services to Crippled Children (DSCC) continues to be the removal of barriers to optimal growth and development for these children.

The purpose of this report is to describe the recent efforts of DSCC to pursue the goal of assisting families so that children with handicaps can develop to their full potential for health, education and self-support. Major activities initiated during the report period include locally based and family-centered service delivery, enhancement of quality of care through standards development, and state-level management improvements.

The Department expresses its sincere gratitude to local health departments, hospitals, physicians, other providers of care, the Legislature and the Executive Office for their commitment and cooperation in serving Michigan children with handicapping conditions. Our collaborative efforts hold the most promise for better service to children and their families.



Gloria R. Smith, Ph.D., M.P.H., F.A.A.N.
Director
Michigan Department of Public Health

EXECUTIVE SUMMARY

Children with handicaps have a right to the best quality of life possible. They should be given every opportunity to develop to their maximum potential for health, education, self-support and self-fulfillment. Michigan's Division of Services to Crippled Children is dedicated to these goals. They will be reached only when physical, social, psychological and economic barriers are eliminated to the extent possible and full access to appropriate services is assured.

The Division of Services to Crippled Children of the Michigan Department of Public Health supports an entire continuum of care with a focus on activities which prevent the actual occurrence, interrupt or terminate the progress of, and reduce the impact of handicapping conditions.

The Division functions are carried out at the local, regional and state level. Major services include prevention, casefinding, diagnosis, medical care and treatment, and case management.

Preventive services include support of the Michigan Genetic Services Program, neonatal intensive care programs in hospitals and locally arranged otology clinics throughout the state. A variety of sources contribute to casefinding efforts, with referrals received from physicians, public health nurses, hospitals, and families.

Free diagnostic evaluation services are offered to all Michigan children with a suspected handicapping condition. Over 15,000 children are evaluated each year at hospital clinics, program-sponsored field clinics and other approved sites.

Treatment services are provided for all children who are medically and financially eligible. The Division assists families by assuming all, or part of, the cost of related treatment for the handicapping condition, recognizing that the high cost of care often creates an economic barrier to these important services. Care is provided by over 3,000 professionals of whom 1,500 are specialty-trained physicians. The hospitals, clinics, specialty centers and physician specialists must be approved to deliver care. Michigan is fortunate to have highly qualified individuals throughout the spectrum of our specialty health care system. Delivery of these services by a multidisciplinary team approach is supported as the optimal way to meet the complex needs of children with handicaps.

Strengthening services at the community level has been a Division priority over the last several years. Locally Based Services, a method of providing community-based support for identifying the needs of those with chronic illness and handicapping conditions and their families and responding through a variety of support mechanisms, has been the primary focus of this endeavor.

Initiated with ten local health departments in FY 83-84, Locally Based Services now involves 46 of the 48 local health jurisdictions in the state. The program components of program representation, family assessment, and case management are expanded upon in later sections of this report.

Resources to support these services to handicapped children were gained from several sources during the report period. The State of Michigan provided almost 60 percent of the funds. The other major sources were federal funds, i.e., Medicaid (Title XIX) and Crippled Children Services (Maternal and Child Health Block Grant), followed by donations and repayments. Expenditures for medical care and treatment increased from 22.4 million dollars in 1984-85 to 27.1 million dollars in 1985-86. This does not include concurrent increases in support of other services. Children with disabling conditions in 17 diagnostic groups received assistance. Clients within two of those groups, congenital anomalies and diseases of newborn, consumed 44 percent of these expenditures.

Future directions include strengthening services delivered in the community; recognizing and supporting the significant role of families in the delivery of care; improving coordination between specialty and community care; promoting high standards of care for children with handicapping conditions; and improving operational efficiency.

THE DIVISION OF SERVICES TO CRIPPLED CHILDREN

The philosophy of the Division of Services to Crippled Children (DSCC) has been that children with handicaps have a right to develop to their maximum potential for health, education, self-support, and fulfillment. The Division is dedicated to these goals and realizes that they can only be reached with the help and support of the family. The Division further believes that to reach these goals, physical, social, emotional, and economic barriers should be eliminated, to the extent possible, and full access to appropriate services should be assured.

POPULATIONS SERVED

The programs administered by the DSCC focus on:

- Persons under age 21 defined under Section 5801, Part 58, Act 368 of 1978 who meet medical and financial eligibility requirements.
- Persons over age 21 with cystic fibrosis or hereditary coagulation defects.
- Persons under age 16 who are eligible for Supplemental Security Income (SSI) and have 1) demonstrated financial need; and 2) evidence of a severe physical, emotional, or mental handicapping condition.
- Children with multi-limb deficiencies who require sophisticated treatment services to respond to these handicaps. These services are typically not available in their city or state. Such highly specialized services are provided at the Area Child Amputee Center, Grand Rapids, Michigan.

An internal DSCC program review was initiated in the fall of 1982 to strengthen the Division's capacity to enable all children with handicaps to grow and develop to their full potential. Two of the recommendations derived from that review were 1) integration of the Crippled Children Program (CCP) and the Supplemental Security Income-Disabled Children Program; and 2) strengthening services at the local level. Having received priority attention, these two recommendations formed the basis for DSCC planning to make locally based services available to the combined CCP and SSI-DCP populations.

To provide local program representation, assessment for service needs, and case management (when indicated), the Locally Based Services Project (LBS) began in 1984 with 10 local health departments representing 20 counties in Michigan. The objective was to increase program capacity to assess need, casefind, and to provide comprehensive local services and support to children and their families. By September 1985, LBS had been extended to 46 local health departments covering 81 of the 83 Michigan counties.

The legal authority, eligibility criteria, and entitlements are somewhat different for the CCP and SSI-DCP. Conversely, some children are dually eligible for both. Due to the separate legal authority for these programs, some of the distinctions must be retained pertaining to the types of eligible conditions and the sources of funds for coverage of medical care. The chart on the following page provides a synopsis of the major characteristics of the two programs, CCP and SSI-DCP.

MAJOR CHARACTERISTICS
OF CCP AND SSI-DCP

CCP	SSI-DCP
Eligibility Criteria:	Eligibility Criteria:
Age: Under 21. Note: Through a special authorization, individuals age 21 and over with CF and coagulation defects are CCP eligible.	Age: Under 16
Medical: Severe physically handicapping conditions.	Disability: Severe physically, emotionally or mentally handicapping conditions.
Financial: 1) No arbitrary income ceiling; 2) Medicaid, wardship, and certain adoptions render automatic eligibility; 3) scale for higher income eligibility by client payment contracts.	Financial: Income ceiling.
Determination Procedures:	Determination Procedures:
Both medical eligibility and financial participation determined by DSCC regional office.	Medical eligibility determined by Disability Determination Service, financial eligibility determined by Social Security Administration.
Medical eligibility determined first, then financial.	Financial eligibility determined first, then medical.
Medical eligibility and financial participation redetermined annually.	Medical redeterminations depend on the type of disability and date of initial decision.
Benefits and Coverage:	Benefits and Coverage:
Medical Care and Treatment services are covered only when care is related to handicapping condition.	All recipients receive Medicaid.
Recipients do not directly receive money.	Recipients receive a monthly subsistence money grant (mostly Federal money, small state supplement).
Medical care is only reimbursed for services rendered by DSCC - approved providers, or services recommended/ordered by the DSCC - approved specialist and only as related to the CCP qualifying condition.	Medical care is reimbursed for any Medicaid-enrolled provider.

ELIGIBILITY FOR SERVICES

The Crippled Children Program

A "crippled child" refers to a single or married individual under 21 years of age whose activity is or may become so far restricted by physiological or structural defect as to reduce normal capacity and whose optimal potential can be best benefited by specialized care. Additionally, persons over 21 with cystic fibrosis or hereditary coagulation defects (hemophilia) may qualify for the CC program.

Once a potential CC recipient has been located, the eligibility determination process begins. In addition to residency and citizenship requirements, the program uses two eligibility criteria: medical and financial.

Medical eligibility is always determined first and is based on information received from medical providers. The Regional Medical Coordinator (a physician) or other regional office personnel under the Regional Medical Coordinator's supervision, is responsible for the consideration of several factors in medical eligibility determination. These factors are: the type of condition; severity of the condition; and long-term effects of the condition on the child and his/her family. Each case is evaluated individually based on these factors as documented in the medical reports. Some diagnoses, such as diabetes and asthma, are only eligible for the Program in their most severe conditions.

The Crippled Children Program covers physical conditions that require care by medical or surgical specialists and are handicapping in nature. These conditions include, but are not limited to:

- amputation
- birth defects
- cerebral palsy
- hearing pathology
- cleft palate and cleft lip
- myelodysplasia
- medical and surgical eye conditions
- muscular dystrophy
- certain heart conditions
- epilepsy and other neurologic disorders
- paralysis/spinal injuries
- cystic fibrosis and other chronic lung diseases
- limb deformities
- hemophilia
- neonatal disease

All medically eligible clients are potential recipients of CC services. Once medical eligibility is established, there is an evaluation of the family's financial resources. Financial approval is automatically established if the potential recipient is: receiving Medicaid (Group I); a ward of the county, state, or a private child placement agency; or adopted, where the handicapping condition existed prior to the final adoption. If a family is not automatically eligible, financial participation by the client is determined on the basis of gross income (minus four specific allowable expenses) and family size. The Michigan Public Health Code, Act 368, of 1978 requires families to share in the cost of their child's care through a payment agreement with the State of Michigan according to a payment schedule established by DSCC. These families agree to pay an established amount, which may be adjusted if the family's financial situation changes during the eligibility period.

Both medical eligibility and financial participation are redetermined annually by DSCC.

The SSI-Disabled Children's Program

Supplemental Security Income (SSI) is a federal program of financial assistance for disabled or blind persons who have a low or moderate income or whose families receive public assistance. It is administered by the Social Security Administration (SSA). To be eligible for the Supplemental Security Income - Disabled Children's Program (SSI-DCP) a child must be under the age of 16 and eligible for SSI on the basis of the child's financial resources and a demonstrated severe physical, mental, or emotional impairment. The disability must be of such severity as to significantly affect the child's age-appropriate growth and development and have lasted, or be expected to last 12 months, or to result in death. Thus, evidence as to the extent or degree of impairment, in addition to evidence as to the diagnosis, is required to make a disability decision. While income and resources for SSI are reviewed annually by SSA, review of disability factors for SSI continuing eligibility depends on the nature of the condition and the applicant's age.

The Disability Determination Service (the area within the Michigan Department of Education which makes disability determinations for SSI) refers all SSI-eligible children under the age of 16 to DSCC. These children are thereby entitled to receive DSCC services and may also be concurrently eligible for Crippled Children Program coverage.

SERVICES

Children with handicaps require comprehensive care from a variety of sources, including services to address health and medical needs, psychosocial, developmental, rehabilitative, and educational needs. There are many obstacles to the appropriate delivery of care to meet these wide-ranging concerns. The burden on these children and families includes financial stress, physical pain and/or discomfort, emotional stress, social stigma, and the frustrations of finding a consistent network of support. For the low income family, these problems are compounded by the added stress imposed by the economic situation.

The Division of Services to Crippled Children provides a range of services to children with special health care needs, and to their families. Such services support the goals of prevention, early diagnosis, comprehensive assessment, medical care and treatment, and management of services to meet identified needs. DSCC services are provided by a variety of health professionals, and in various settings, including inpatient and outpatient hospital care, specialty clinics, and home nursing care. The following pages describe the services component of the DSCC.

Prevention

Prevention services focus on a broad range of activities, the purpose of which is to decrease the incidence of preventable handicapping conditions and to safeguard against the development of secondary complications or additional handicaps. Examples of preventive services supported by the Division include genetic clinics for screening and counseling; screening of newborns for specific conditions, such as phenylketonuria (PKU) and galactosemia; scoliosis screening; vision screening; neonatal intensive care programs in hospitals; and locally arranged otology clinics throughout the state.

Habilitative and rehabilitative services (known as secondary and tertiary prevention) are promoted to prevent disability arising from failure to completely and adequately treat a known or suspected handicapping condition.

Casefinding

Handicapped children need expert care if they are to achieve their maximum potential. Accordingly, DSCC is empowered and required by law to locate and serve those persons under 21 in need of health services for crippling or potentially crippling conditions.

Early detection of handicapping conditions is effective and cost efficient since it allows for thorough evaluation and appropriate treatment planning, timed so that the child can receive maximum benefit. Because many conditions progress rapidly, early detection is imperative in order to cure or lessen the effects of the handicapping condition and reduce the cost of care.

DSCC uses a number of casefinding methods to locate children with handicapping conditions. The three major casefinding methods are: the diagnostic referral system, field clinics, and direct referrals.

a) Diagnostic referral system: Any child suspected of having a handicapping condition (which would qualify him/her medically for the Crippled Children Program) may have a diagnostic evaluation, from a DSCC approved clinic or specialist. These are provided free of charge, except that insurance coverage will be billed.

   Referral for diagnostic evaluation may be initiated by local health department nurses where Locally Based Services agreements are in place. Currently in Wayne and Macomb counties, the referral must be authorized by the DSCC regional office.

   Diagnostic evaluations are usually performed in outpatient hospital-based specialty clinics. Currently, over 60 hospitals in Michigan have outpatient specialty clinics which are approved for CCP diagnostic services. Occasionally, referral to a clinic is not practical. For example, if a DSCC approved clinic is not within a 60 mile radius of the child's residence, a diagnostic evaluation may be authorized in a DSCC approved physician's office. In addition, there are certain types of evaluations which may appropriately be authorized in a physician's office, due to the unique diagnostic equipment requirements of a given specialty (e.g., opthalmology, otology, neurology, and pediatric allergy).

   When the diagnostic evaluation has been completed, the physician or clinic forwards the results to the DSCC regional office, where a decision regarding medical eligibility for the Crippled Children Program is made.

b) Field clinics: DSCC sponsors specialty clinics in order to provide expert diagnostic services in geographic areas where specialty medical service is not ordinarily available. Since they are diagnostic in nature, clinic services are available without charge to the family.

except for billing to third party coverage when it is available. Physician specialists from other areas of the state are brought in to provide the medical services. Nursing and other necessary assistance is usually provided by the local health department and hospital where the clinics are operated.

DSCC supports field clinics organized by the Michigan Genetic Service Program, MDPH (estimated 1,000 patients seen each year), the Hemophilia Foundation of Michigan (estimated 50 patients seen), and the Hearing and Speech Unit, MDPH (estimated 6,000 patients seen).

Medical information from a field clinic evaluation is forwarded to the DSCC regional office for a decision regarding medical eligibility for the Crippled Children Program.

c) Direct referrals: A large number of children are already under the care of a physician when a handicapping condition is diagnosed, or when the family's circumstances change so that they need assistance with the cost of medical care and treatment. A physician may make a direct referral to the Crippled Children program by submitting medical information on the "Medical Eligibility Request Form." As long as the physician is qualified to determine the given diagnosis, this form is accepted for the purpose of determining medical eligibility. If medical eligibility cannot be confirmed on the basis of the report, a diagnostic referral to a DSCC-approved provider is appropriate. Hospitals may also make direct referrals on the same form.

Casefinding for persons eligible for DSCC services also includes receiving referrals from the Disability Determination Service (DDS) of persons who are eligible for Supplemental Security Income (SSI) under the SSI-Disabled Children's Program. These children and their families may receive assessment and case management services from public health nurses in LBS counties. In addition, referrals of persons determined to be ineligible for SSI are reviewed for potential medical eligibility for the Crippled Children Program. In these cases the DSCC regional office contacts the family to secure permission for follow-up by the local health department.

Program Representation

Program representation refers to those activities performed throughout the State of Michigan to identify the services provided by DSCC such that individuals in need of those services become aware of their existence. Activities include public relations, community, family and provider education, and casefinding. The goal is to assure that all eligible children will be identified and enrolled for DSCC services, and that the community and participants are well informed of the program.

This service is an integral part of LBS and local health departments have become a focal point of information dissemination for their surrounding communities. This is done in coordination with DSCC providers, other service agencies and the DSCC regional offices. Broadening this information network has supported Division casefinding efforts described in a later section.

The activities of Program Representation include:

a) Continued education of the enrolled families, service providers and the community, in order to increase awareness and understanding of DSCC services;

b) Coordination with agencies who serve the handicapped population in order to achieve efficient systems for casefinding, referral and service delivery to eligible children;

c) Assuring that medical evaluations are conducted on potentially handicapped children so that medical eligibility may be determined by DSCC;

d) Public relation activities to increase visibility, support, and participation in programs serving handicapped children;

e) Serving as a resource for the family in resolving processing and procedural problems and questions.

Family Assessment for Service Needs

Family assessment is a process by which families are assisted in identifying both the needs of family members in all areas and their options in gaining assistance to have those needs met. Through the local health department, the family has an opportunity to meet with a qualified professional for the purpose of identifying their concerns via a family assessment. Parents may need considerable support in their efforts to manag their child's special health care needs.

Information is collected in the areas of financial, social/emotional, physical/health care, developmental, and educational/vocational needs. As problems or concerns are discovered, a qualified professional is available to identify appropriate interventions or resources with the family and initiate services if needed.

The following chart identifies the number of families referred to local health departments for a Locally Based Services family assessment in 1984, 1985, and 1986. Total referred are those families referred to a local health department for LBS; cases completed reflects both family assessments which have been provided and inactivated cases which reflect families that could not be located, moved out of state, etc. Cases outstanding reflect those referrals still in process.

REFERRALS TO LHDs FOR LBS FAMILY ASSESSMENT

	1984	1985	1986
TOTAL REFERRED	4,847	7,072	15,309
CASES COMPLETED	3,612	4,185	10,886
CASES OUTSTANDING	1,235	2,887	4,423
% CASES OUTSTANDING	25%	41%	29%

Medical Care, Treatment and Supportive Services

"Chronic illness does not strike individuals; it strikes the whole living unit of the family. The presence of a chronic illness creates such enormous financial and emotional demands that every family member is affected - the parents and brothers and sisters as well. The ability of the family to respond and the manner in which its members choose to do so can be the decisive element in how a child learns to work with and overcome the effects of a chronic illness."[1]

Historically the major aspect of Division services had been to assist families in the financing of medical care and treatment needed by their child. The recognition that the needs of these families go beyond financial support and are more effectively served in their own communities has driven changes in the Division's programs, such as the implementation of Locally Based Services. To meet the broad-based needs of families, the Division covers a wide range of services, such as hospital care, occupational and physical therapy, respite services, pediatric home nursing care, and medical supplies and equipment, as well as assistance with transportation to care facilities.

During the course of treatment, each case is monitored with the goal of assisting the family in ensuring that the child gets the best and most appropriate health care available. Monitoring of cases includes the authorization of providers and prior approval of certain services and equipment, as well as making available the services of a public health nurse to assist with any service delivery problem and advocacy.

Case Management

Case management is a process by which families are assisted to gain skills and independence in problem solving, management of the human services system and self advocacy. The variety of problems confronting the family of a child with special health care needs typically include such issues as accessing services, providing daily care, meeting costs of care, and maintaining stability in the family unit. These can at times become overwhelming demands for the family. Providing families with professional assistance in managing their identified needs promotes optimal growth and development for each family member.

Criteria are applied during the family assessment process to determine if a family needs case management services. Since the implementation of Locally Based Services in 1984, between thirteen and nineteen percent of those families assessed have requested and been provided case management.

[1] Massie, R.K. Jr. "The Constant Shadow: Reflections on the Life of a Chronically Ill Child," in N. Hobbs and J.M. Perrin (Eds.) Issues in the Care of Children with Chronic Illness: A Sourcebook on Problems, Services and Policies, San Francisco: Jossey-Bass, 1985.

Activities of DSCC case management include:

a) Clarifying the goals of planned intervention;

b) Providing the family with information about available services and options for care, service rights and entitlements;

c) Preparing the family for referrals to appropriate resources;

d) Coordinating services, establishing common goals, and identifying responsibilities for the provision of specified services;

e) Representing the family when necessary in negotiations to obtain necessary services (including ongoing case management services) by the most appropriate provider;

f) Assisting the family in developing skills in problem identification, exploration of alternatives and decision making.

The Division recognizes that there are other resources available in local communities which provide case management services to DSCC clients. So as not to duplicate services, three options for case management under LBS were identified for families in need of this support. These include DSCC case management which is provided directly by the LBS/LHD nursing staff; case management by an other agency within the community, e.g., Community Mental Health; and combined case management which is provided both by the LHD and an other community agency.

The following chart provides comparative data for calendar years 1984, 1985 and 1986 for the total number of families provided case management according to the three designated alternatives cited above. Mean percents are also indicated. Case management is provided only to those who have completed the LBS family assessment process.

CASE MANAGEMENT TOTALS AND MEAN PERCENTS

	1984		1985		1986	
	CM #'s	Mean Percents	CM #'s	Mean Percents	CM #'s	Mean Percents
Total # CM	548	16%	527	13%	1,490	19%
CM DSCC/LBS	447	81%	346	66%	817	55%
CM Other	79	15%	78	15%	505	34%
CM Combined	22	4%	103	19%	16%	11%

PROGRAM ADMINISTRATION

The Division of Services to Crippled Children is organizationally located in the Bureau of Community Services of the Michigan Department of Public Health. Division activities occur at three distinct but interrelated levels: central office, regional offices and local health departments.

Central Office

The DSCC central office provides overall executive direction and program administration for the Division. Central office functions include: policy analysis and development, fiscal and program management, and professional consultation.

Policy development includes the analysis of the current and expected problems of families with children who have handicapping conditions and the formulation of Division goals and objectives to address these problems.

Program and fiscal management includes use of data systems for identification and enrollment of the children, and for the purchase of medical care and treatment for recipients. Through an agreement with the Michigan Department of Social Services, the Medical Services Administration as fiscal intermediary makes payments to providers for DSCC covered and authorized medical services through its Invoice Processing System.

Professional consultant services are provided to a wide array of individuals and groups. The consultants are often involved in providing staffing assistance to task forces convened for developing standards of care and other quality assurance activities, and for advocating improved service coordination among state agencies and specialty care providers.

A unique program service administered through the Division for many years is the Area Child Amputee Center (ACAC), located at Mary Free Bed Hospital in Grand Rapids. The Amputee Center offers specialized diagnostic, treatment and rehabilitative services to children with limb-deficiencies from birth to age twenty-one both from within and outside of Michigan. These deficiencies are either congenital or the result of disease or trauma. The team of experts which provides care to these clients consists of an orthopedic surgeon, occupational therapist, physical therapist, nurse clinician, social worker, and a limb maker. The team efforts of these professionals have helped to make the Amputee Center a nationally recognized facility for expert treatment of children with multi-limb deficiencies.

Regional Offices

Regional offices located in Detroit, Grand Rapids, Lansing, Marquette and Pontiac serve as the primary point in organizing the delivery of services for the recipients. They are responsible for: approving medical eligibility; determining financial participation and client payment agreements; determining prior-approval for certain services; maintaining case records; and communicating with providers, local health departments, and other agencies. Professionals in the regional offices also provide consultation services to the Medical Services Administration of the Michigan Department of Social Services.

These offices are also directly involved in providing in-service training and monitoring the delivery of services. With the onset of Locally Based Services, the consultation role of regional offices has expanded to include technical assistance in the implementation of LBS contracts, and conducting audits to enhance the quality of family assessment and case management services provided. The map at the end of this section indicates the regional offices of DSCC within the regional divisions of the Bureau of Community Services.

Local Health Departments

In recognition of the impact on the family when a child has special health care needs, and in response to families' needs for local assistance in gaining access to needed health care and other community resources, the DSCC introduced Locally Based Services in FY 83-84. Through this endeavor, local health departments serve as a community based resource to assist families in accessing needed services, not only from DSCC, but also from other service agencies in their communities. This is done via the LBS program components of program representation, family assessment, and case management described in a previous section of this report.

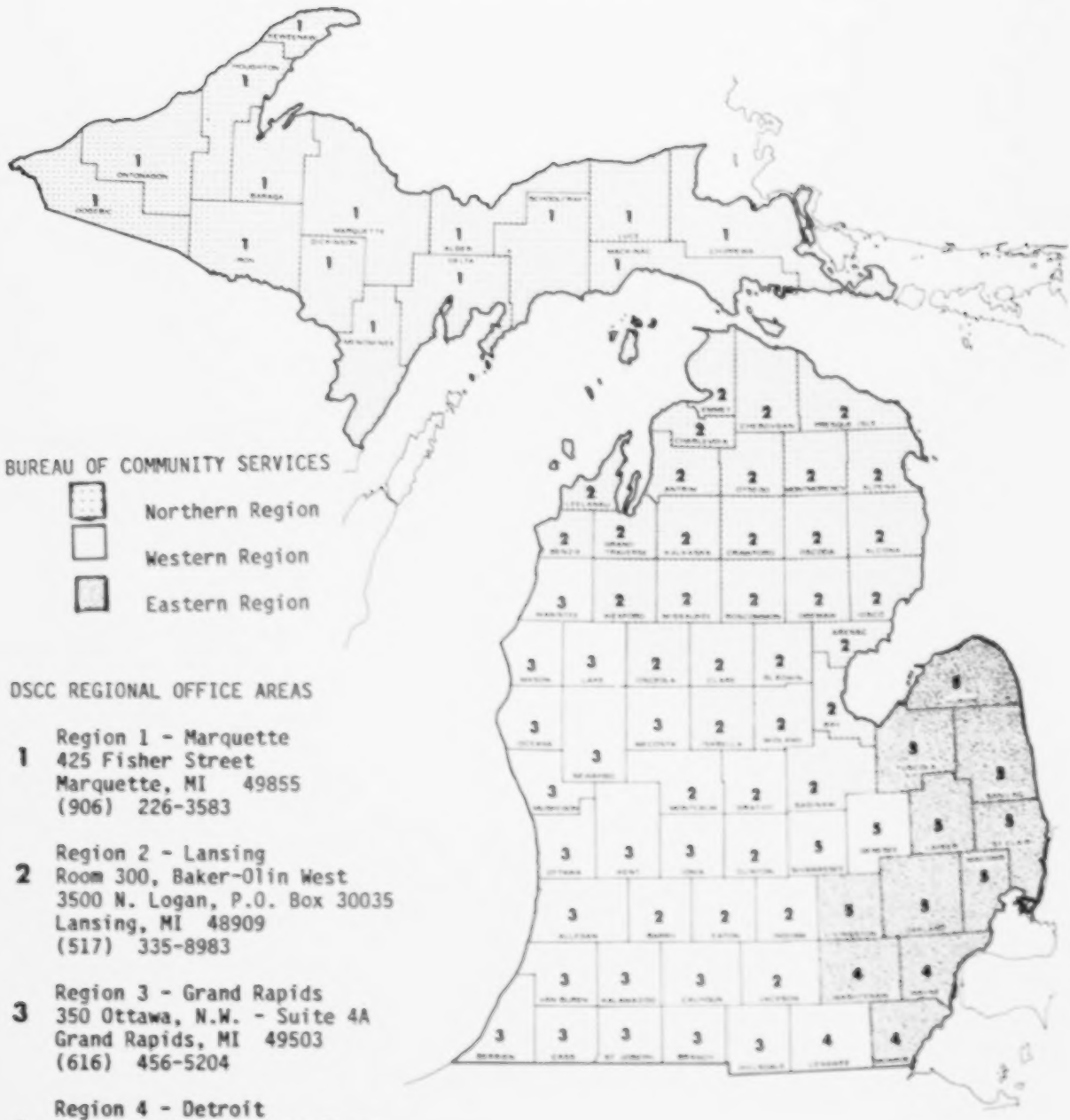
Implementation of LBS has occurred in three phases, and was initiated with ten local health departments in FY 83-84. Realization of Phase II and III contracts in 1985 brought the project to near statewide scope. Locally Based Services are not yet implemented in Wayne County, excluding City of Detroit, and Macomb County.

Program services are provided by public health nurses and clerical staff, referred to as LBS Representatives. In addition, each local health department designates a senior level Public Health Nurse to serve as the local LBS Coordinator whose responsibility it is to oversee program implementation and be the primary contact between the local health department and the Division Central and regional office staffs.

MICHIGAN DEPARTMENT OF PUBLIC HEALTH

BUREAU OF COMMUNITY SERVICES

DIVISION OF SERVICES TO CRIPPLED CHILDREN



BUREAU OF COMMUNITY SERVICES

Northern Region

Western Region

Eastern Region

DSCC REGIONAL OFFICE AREAS

1 Region 1 - Marquette
425 Fisher Street
Marquette, MI 49855
(906) 226-3583

2 Region 2 - Lansing
Room 300, Baker-Olin West
3500 N. Logan, P.O. Box 30035
Lansing, MI 48909
(517) 335-8983

3 Region 3 - Grand Rapids
350 Ottawa, N.W. - Suite 4A
Grand Rapids, MI 49503
(616) 456-5204

4 Region 4 - Detroit
Michigan Plaza - North Tower
1200 Sixth Street
Detroit, MI 48226
(313) 256-3682

5 Region 5 - Pontiac
1895 - North Perry
Pontiac, MI 48055
(313) 373-0500

FUNDING

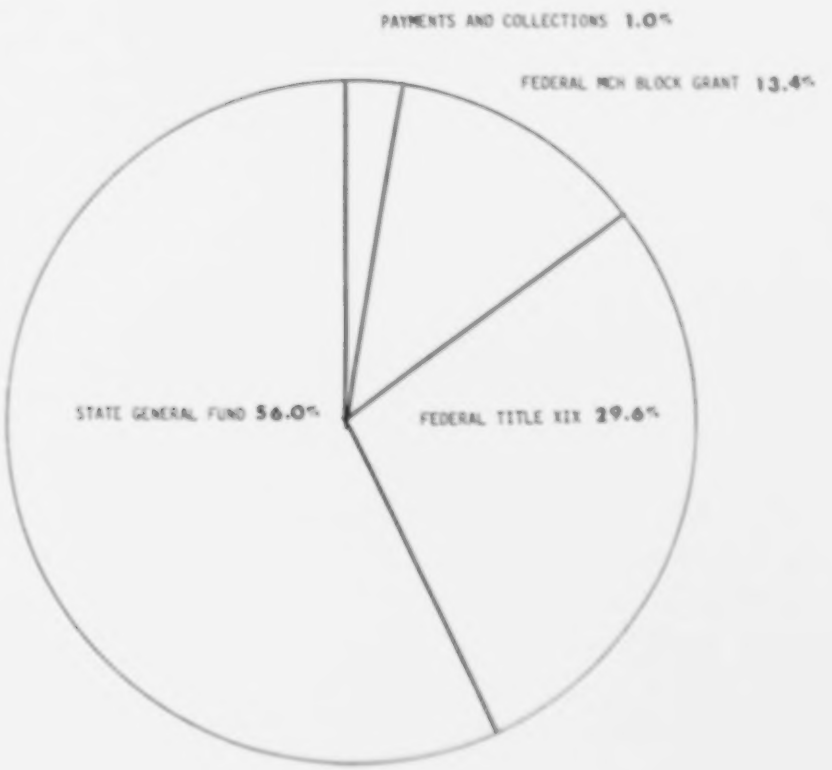
Several sources of funds support the work of the DSCC. The State of Michigan is the major funding source, along with the Federal government, private donations, and family participation in payment agreements for reimbursement to the state.

Federal funds for the program are received via the Maternal and Child Health Block Grant. Title V of the Social Security Act of 1935 historically has provided funds to each state for crippled children's services. Medicaid, (Title XIX) funds are designated for payment of medical care for handicapped children eligible for both Medicaid and the Crippled Children Program. Another source of federal funds is the grant to the Area Child Amputee Center which is administered by the Division. As noted previously, this Center provides services to Michigan children as well as to children from other states.

The Michigan Crippled Children's Trust Fund is authorized by the Public Health Code. Contributions of money, securities, and personal property may be received, and the income from these is dedicated to meet special needs.

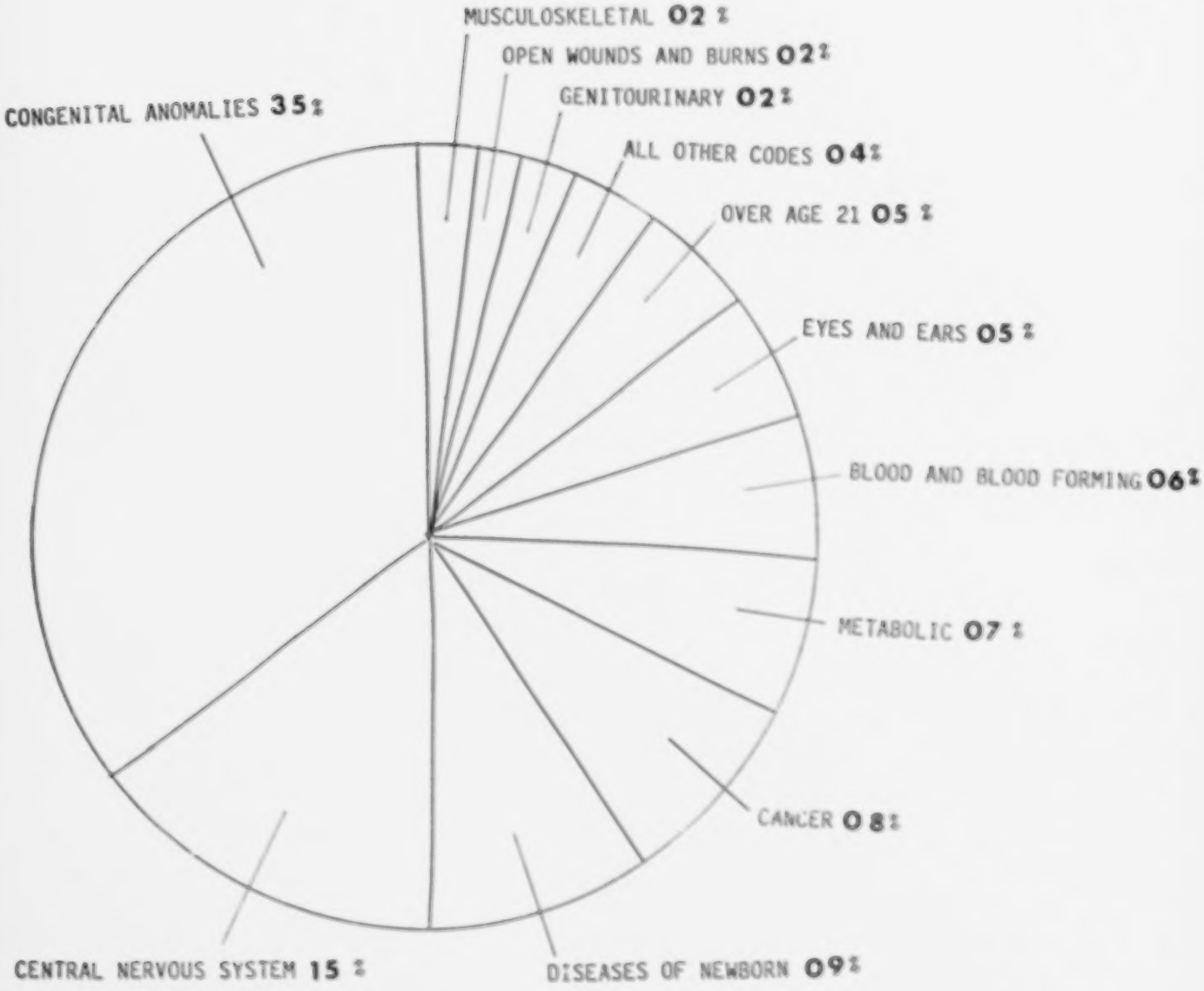
The following chart shows the proportionate source of funding:

FUNDING BY SOURCE



Expenditures

The following chart displays expenditures for medical care and treatment for enrolled individuals. The tables which appear in the Appendix provide detailed data on these expenditures for each year.



FUTURE DIRECTIONS

Short-Range Goals

The joint state and local effort to implement Locally Based Services has created a foundation for strengthening community services delivery. Specific goals are to support increased local program responsibility, to improve and coordinate support arrangements in the home and community, and to increase the participation of parents in the management of their child's care.

Continuing quality assurance efforts will build on the guidelines developed for the care of children with myelodysplasia and ventilator dependencies, in partnership with the provider community. The next areas to be addressed will be guidelines for the care of children with oral cleft and phenylketonuria, guidelines for pediatric home nursing, and program auditing of Locally Based Services.

An extensive review of DSCC's mission, goals, and objectives was completed with substantial public and private sector input. As a result, a provider approval and review process will be initiated and the content and scope of covered services will be assessed. During the next year's schedule, operational processes will be automated where feasible and a comprehensive data management system will be designed. Legislative initiatives are expected to occur on the most appropriate title for services in order to focus on the special needs of children and their families as opposed to a medical handicap.

Long-Range Goals

To provide leadership in the development of an organized system of health care for children with special needs, important functions of advocacy, needs assessment, planning and evaluation, resource development, quality assurance, provision of consultation and technical assistance, and coordination must be strengthened. The long-range priorities are:

- To attain comprehensive and quality care by improving the balance of specialty care services in response to medical, nursing, and social needs. Developing guidelines for the care of specific conditions will be continued and planning for a broad range of services initiated. Prevention initiatives will be pursued in collaboration with other maternal and child health services such as primary care, prenatal care, genetics counselling, nutrition, and injury prevention.

- To promote the shift toward community-based care through the collaborative efforts of government, private and voluntary agencies, and parent and professional groups at the local, state and federal levels. Special emphasis will be placed on coordination between specialty and community care, the financing of community and in-home care for children, and the enhancement of family-centered care.

APPENDIX

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TABLE I
Expenditures for Medical Care and Treatment Provided Children by County of Residence

County	Children Provided Treatment		Care and Treatment Expenditures	
	9/30/85	9/30/86	9/30/85	9/30/86
TOTALS	14,406	15,483	22,416,130.12	27,107,551.71
Alcona	24	22	19,128.95	45,277.77
Alger	22	23	6,025.34	5,837.27
Allegan	125	144	293,529.96	308,536.61
Alpena	98	103	132,107.49	178,054.58
Antrim	62	51	56,709.76	73,339.47
Arenac	48	54	37,789.02	72,693.14
Baraga	16	19	8,153.84	25,003.65
Barry	89	98	144,117.96	233,422.03
Bay	241	226	189,153.55	364,335.77
Benzie	32	39	9,817.33	33,225.18
Berrien	238	264	655,374.37	609,828.97
Branch	101	101	210,869.85	208,568.98
Calhoun	225	240	379,698.31	587,978.80
Cass	66	71	278,303.08	171,121.00
Charlevoix	68	84	142,006.07	186,462.02
Cheboygan	86	84	58,980.33	55,608.59
Chippewa	49	52	87,752.27	98,412.02
Clare	76	88	112,459.02	144,191.57
Clinton	130	128	279,476.20	286,521.74
Crawford	34	41	24,931.35	50,861.07
Delta	78	94	80,395.02	152,356.20
Dickinson	29	30	32,883.92	17,592.99
Eaton	197	202	167,190.18	289,597.01
Emmet	95	101	148,351.78	124,739.43
Genesee	474	532	658,929.68	1,007,540.60
Gladwin	41	43	109,218.44	128,165.13
Gogebic	21	25	9,771.11	14,740.47
Gd. Traverse	234	275	267,507.59	437,025.62
Gratiot	92	100	101,561.95	178,786.49
Hillsdale	116	119	319,462.87	307,811.61
Houghton	91	90	89,711.28	92,672.16
Huron	122	145	150,398.85	135,709.68
Ingham	705	716	991,707.01	973,065.87
Ionia	108	118	124,288.93	171,683.43
Iosco	64	85	54,184.79	92,802.60
Iron	26	31	28,535.09	70,181.32
Isabella	117	131	149,000.13	141,506.28
Jackson	297	354	396,978.51	587,482.08
Kalamazoo	289	279	464,282.32	505,387.08
Kalkaska	64	61	111,716.68	75,221.21
Kent	735	861	752,935.45	1,280,304.52
Keweenaw	2	3	241.20	1,258.94

TABLE I
Expenditures for Medical Care and Treatment Provided Children by County of Residence

(Continued)

County	Children Provided Treatment 9/30/85	Children Provided Treatment 9/30/86	Care and Treatment Expenditures 9/30/85	Care and Treatment Expenditures 9/30/86
Lake	17	22	20,285.33	25,311.25
Lapeer	127	150	137,665.96	218,443.31
Leelanau	51	50	21,021.44	18,959.22
Lenawee	173	183	155,234.12	316,644.89
Livingston	180	201	212,989.02	316,734.46
Luce	20	15	16,151.32	7,551.82
Mackinac	16	20	7,757.16	30,194.71
Macomb	727	761	1,337,301.41	1,566,131.46
Manistee	40	39	49,353.89	54,527.82
Marquette	165	171	156,883.25	293,034.96
Mason	63	68	104,007.78	121,266.45
Mecosta	88	106	155,824.67	111,552.61
Menominee	61	58	33,914.41	38,240.93
Midland	156	142	132,191.51	220,062.69
Missaukee	37	41	29,106.59	58,042.67
Monroe	177	217	230,745.56	409,494.53
Montcalm	153	162	149,047.38	114,714.47
Montmorency	26	37	45,850.32	86,865.54
Muskegon	230	258	483,804.58	474,273.62
Newaygo	82	81	94,601.87	83,133.18
Oakland	1,036	1,108	1,852,228.44	1,829,307.40
Oceana	39	33	51,499.95	57,000.15
Ogemaw	52	51	33,921.08	52,316.96
Ontonagon	24	19	15,662.84	17,950.52
Osceola	101	118	176,473.61	188,117.18
Oscoda	18	22	6,147.93	53,042.51
Otsego	80	71	61,427.00	92,156.27
Ottawa	215	249	227,477.48	387,539.51
Presque Isle	51	53	139,462.83	73,477.64
Roscommon	40	48	40,187.81	82,542.86
Saginaw	383	394	529,278.61	566,386.78
St. Clair	376	399	423,595.95	448,199.81
St. Joseph	138	145	152,237.25	204,878.68
Sanilac	99	130	65,768.90	142,363.08
Schoolcraft	34	31	71,136.98	67,760.21
Shiawassee	139	178	134,216.55	347,710.99
Tuscola	155	195	90,736.97	221,592.74
Van Buren	161	182	444,630.61	477,264.59
Washtenaw	280	308	416,588.95	677,958.39
Wayne	2,474	2,546	5,500,515.62	5,941,152.17
Wexford	89	92	72,700.99	88,154.03
Unknown	6	2	859.37	605.70

TABLE II
Expenditures by Diagnosis Groups and Conditions for Medical Care and Treatment Provided Children

Diagnosis Groups and Conditions	04/30/85		04/30/86	
	Expenditures	Cases	Expenditures	Cases
Total - All Diagnoses	22,416,130.12	14,406	27,107,551.71	15,483
Group I. Infective and Parasitic Diseases	20,035.78	28	33,512.15	35
1. Late effects of Parasitic Diseases	16,981.06	20	9,890.42	19
2. Late effects of Viral Encephalitis	2,717.98	05	20,127.01	04
3. Other Infectious Diseases	336.74	03	3,512.72	09
Group II. Neoplasms	1,741,500.99	757	2,243,511.96	836
4. Malignant Neoplasms	662,840.22	278	1,079,164.59	309
5. Hodgkins Disease	32,688.14	33	39,064.74	30
6. Leukemia	785,881.33	290	791,853.30	302
7. Other Malignant Neoplasms	62,805.41	39	75,475.88	40
8. Benign Neoplasms	197,285.85	117	257,949.35	125
Group III. Endocrine Nutritional and Metabolic Diseases	1,465,780.32	807	1,870,030.99	878
9. Diabetes, Juvenile	181,086.35	164	273,684.94	202
10. Nutritional Deficiencies	86,001.97	10	121,434.23	12
11. Cystic Fibrosis, Under Age 21	676,489.64	278	584,516.14	246
12. Cystic Fibrosis, Age 21 and Over	296,474.77	94	430,650.13	103
13. Other Glandular and Metabolic Diseases	275,727.59	261	399,741.55	295
Group IV. Diseases of the Blood and Blood Forming Organs	1,589,909.56	335	1,587,406.46	334
14. Anemias	258,079.89	120	440,346.44	127
15. Hemophilia, Under Age 21	290,548.34	101	179,944.09	77
16. Hemophilia, Age 21 and Over	886,365.77	60	913,934.61	95
17. Other Diseases of the Blood and Blood Forming Organs	154,915.56	34	103,137.32	32
Group V. Mental Disorders	36.16	02	730.60	05
18. Drug Dependence	00	0	00	0
19. Gilles de la Tourette's Disorder	36.16	02	730.60	05
Group VI. Diseases of the Nervous System and Sense Organs	4,157,986.35	5,059	5,518,658.07	5,344
20. Muscular Dystrophy	95,844.04	32	94,726.62	35
21. Cerebral Palsy	2,097,666.13	1,549	2,770,275.29	1,604
22. Epilepsy	267,438.41	398	374,798.61	410
23. Other Inflammatory Diseases of the Central Nervous System	595,996.90	324	760,074.49	343
24. Diseases of the Nerves and Peripheral Ganglia	112,111.42	77	129,323.61	81
25. Inflammatory Disease of the Eye	168,024.64	337	313,616.56	400
26. Disease of the Ear and Mastoid Process	826,304.41	2,342	1,075,842.89	2,410
Group VII. Diseases of the Circulatory System	350,057.59	178	512,204.64	202
27. Rheumatic Fever with Heart Involvement	7,502.84	13	9,527.63	14
28. Rheumatic Fever without Heart Involvement	09	0	1.36	01
29. Other Heart Diseases	189,980.25	98	234,848.29	103
30. Other Diseases of the Circulatory System	152,574.50	67	263,831.37	83
Group VIII. Diseases of the Respiratory System	328,482.89	448	352,195.29	503
31. Asthma	324,240.80	480	342,492.88	495
32. Paralysis of Vocal Cords or Larynx	1,308.62	03	693.96	02
33. Other Diseases of the Respiratory System	3,433.47	05	9,008.44	06
Group IX. Diseases of the Digestive System	334,096.93	195	512,412.55	215
34. Diseases of the Digestive System	334,096.93	195	512,412.55	215

TABLE II
Expenditures by Diagnosis Groups and Conditions for Medical Care and Treatment Provided Children

(Continued)

Diagnosis Groups and Conditions	09/30/85		09/30/86	
	Expenditures	Cases	Expenditures	Cases
Group X. Diseases of the Genitourinary System	650,201.45	209	602,166.37	214
35. Nephritis and Nephrosis	524,108.47	143	445,155.01	141
36. Other Diseases of the Genitourinary System	126,092.98	66	157,011.36	73
Group XII. Diseases of the Skin and Subcutaneous Tissue	23,641.48	32	70,297.12	34
37. Diseases of the Skin and Subcutaneous Tissue	23,641.48	32	70,297.12	34
Group XIII. Diseases of the Musculoskeletal System and Connective Tissue	444,032.77	608	637,404.99	615
38. Arthritis and Rheumatism, Except Rheumatic Fever	131,413.79	145	261,711.93	154
39. Osteomyelitis and Periostitis	4,744.98	06	2,426.76	05
40. Osteochondrosis	66,297.41	56	82,042.97	63
41. Other Diseases of the Bone	20,814.07	16	22,879.61	19
42. Other Diseases of the Joint	18,856.23	17	12,119.14	17
43. Other Diseases of the Musculoskeletal System	19,318.74	29	8,387.36	21
44. Curvature of the Spine	168,500.67	276	208,083.37	271
45. Other Deformities	14,091.97	64	39,753.95	68
Group XIV. Congenital Anomalies	7,738,845.51	4,336	9,700,591.48	4,637
46. Spina Bifida	872,608.33	436	1,194,454.34	467
47. Congenital Hydrocephalus	862,845.96	302	760,066.26	301
48. Other Congenital Anomalies of the Nervous System	298,134.36	104	243,307.62	107
49. Congenital Anomalies of the Heart	1,381,578.06	658	2,179,293.09	700
50. Other Congenital Anomalies of the Circulatory System	1,129,958.37	376	1,374,633.09	347
51. Cleft Palate	195,603.00	220	334,934.27	251
52. Cleft Lip	48,872.36	87	75,382.04	95
53. Cleft Palate with Cleft Lip	668,851.73	653	771,354.25	644
54. Club Foot, Congenital and Acquired	149,062.97	279	203,575.11	297
55. Congenital Dislocation of the Hip	42,497.62	85	118,017.06	77
56. Congenital Reduction Deformity of Limb	129,130.80	172	329,384.92	165
57. Other Congenital Deformity of Upper Limb	16,336.69	34	94,832.97	24
58. Other Congenital Deformity of Lower Limb	6,890.55	11	8,424.72	07
59. Other Congenital Anomalies	1,907,079.47	814	2,054,922.74	1,360
Group XV. Certain Diseases Peculiar to Newborn Infants	2,360,060.54	667	1,752,844.69	635
60. Respiratory Distress Syndrome	904,829.74	229	476,660.62	199
61. Perinatal Chronic Respiratory Disorder	904,773.93	177	745,696.48	156
62. Other Diseases	570,357.37	261	530,287.59	280
Group XVI. Symptoms and Ill-Defined Conditions	723,637.75	486	1,065,479.90	757
63. Sudden Infant Death Syndrome	00	0	292.44	01
64. Deferred, Ill-Defined and Provisional Diagnosis	723,637.75	486	1,065,186.42	756
Group XVII. Injury and Poisoning	472,433.55	214	638,040.56	225
65. Burns	56,181.13	71	208,179.46	73
66. Fractures of Skull, Spine and Trunk	119,194.73	20	186,304.51	26
67. Fractures of Upper Limbs	800.00	01	00	0
68. Fractures of Lower Limbs	2,599.46	05	4,119.10	04
69. Intracranial Injury Excluding those with Skull Fracture	60,894.71	27	95,816.74	35
70. Laceration and Open Wound of Head, Neck and Trunk	3,782.77	08	14,716.98	14
71. Laceration and Open Wound of Upper Limb	833.86	03	00	0
72. Traumatic Amputation of Thumb, Finger(s) Arm and Hand	10,593.97	10	8,506.45	11
73. Traumatic Amputation of Toe(s), Foot or Leg(s)	102,335.69	48	74,188.90	43
74. Injury to Nerves and Spinal Cord	35,920.83	00	3,944.13	02
75. Other and Unspecified Injuries and Reactions	79,467.67	15	32,906.24	17

TABLE III
Ranking of Diagnosis Groups by Number of Children Served

During Fiscal Year 1984-1985

Group Identification	Children
Diseases of the Nervous System and Sense Organs	5,062
Congenital Anomalies	4,341
Neoplasms	757
Certain Diseases of the Newborn	667
Metabolic Diseases	533
Diseases of the Respiratory System	488
Signs, Symptoms and Ill-Defined Conditions	486
Diseases of the Musculoskeletal System	460
All Others	1,612
TOTAL	14,406

During Fiscal Year 1985-1986

Group Identification	Children
Diseases of the Nervous System and Sense Organs	5,394
Congenital Anomalies	4,649
Neoplasms	806
Signs, Symptoms and Ill-Defined Conditions	757
Certain Diseases of the Newborn	635
Metabolic Diseases	563
Diseases of the Respiratory System	503
Diseases of the Musculoskeletal System	458
All Others	1,718
TOTAL	15,483

TABLE IV
Expenditures by Provider Type

Type of Service	84/85 Cases*	84/85 Expenditures	85/86 Cases*	85/86 Expenditures
Physician	10,914	2,103,364.45	12,162	2,876,241.19
Hospital-Outpatient	6,506	984,620.91	6,412	1,295,931.51
Hospital-Inpatient	1,658	12,806,361.46	2,292	14,506,985.30
Convalescent Home Care	460	550,531.75	443	537,300.36
Appliance/Braces	1,073	607,604.96	1,087	741,593.05
Ancillary	10,502	5,363,636.92	11,560	7,149,490.93

*The same recipient may be included more than once in these counts.